Kansas Health Insurance Assistance Program Physicians Form

Kansas Department of Health and Environment, KHIC Program
1000 SW Jackson, Suite 210
Topeka, KS 66612-1274
Fax: (785) 291-3420

CLIENT INFORMATION

Name:

Social Security Number:	**Date of Birth:**	**Participant Card Number:**

I hereby authorize my physician to provide the information requested on this form.
Client Signature/Date:

PHYSICIAN'S INFORMATION

Please attach any supporting documentation such as recent labs, progress notes, etc.

What is patients current medication regimen?

Do you (the physician) expect an increase in medication use over the next twelve (12) months? _____ Yes _____ No
If yes, what are the expected changes?

How often is the client required to receive labwork and see you (the physician)?

Do you (the physician) expect an increase in frequency/quantity of lab and/or office visits within the next twelve (12) months?
_____ Yes _____ No If yes, what are the expected changes?

Do you (the physician) expect the need for home healthcare within the next twelve (12) months? _____ Yes _____ No
If yes, what are expected needs?

Physicians Signature: **Date:**

PLEASE RETURN COMPLETED AND SIGNED FORM TO BELOW NOTED RYAN WHITE CASE MANAGER

Case Manager:	Phone:

Mailing Address: